

**PROPERTY & CASUALTY INSURERS**

**COMPANY NAME:** \_\_\_\_\_ **NAIC Company Code:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
**REQUIRED FILINGS IN THE STATE OF:** MONTANA **Filings Made During the Year 2010**

(1) Check- list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		<b>I. NAIC FINANCIAL STATEMENTS</b>						
	1	Annual Statement (8 1/2" x 14")	1	EO	xxx	3/1	NAIC	
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	
	2	Quarterly Financial Statement (8 1/2" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
	3	Protected Cell Annual Statement	0	0	xxx	3/1	NAIC	
	4	Combined Annual Statement (8 1/2" x 14")	0	EO	xxx	5/1	NAIC	
		<b>II. NAIC SUPPLEMENTS</b>						
	10	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	
	11	Actuarial Opinion Summary	1	N/A	xxx	3/15	Company	Y
	12	Bail Bond Supplement	1	EO	xxx	3/1	NAIC	
	13	Combined Insurance Expense Exhibit	1	EO	xxx	5/1	NAIC	
	14	Credit Insurance Experience Exhibit	1	EO	xxx	4/1	NAIC	
	15	Exceptions to Reinsurance Attestation Supplement	1	N/A	xxx	3/1	Company	
	16	Financial Guaranty Insurance Exhibit	1	EO	xxx	3/1	NAIC	
	17	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
	18	Insurance Expense Exhibit	1	EO	xxx	4/1	NAIC	
	19	Long Term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	
	20	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
	21	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	
	22	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	23	Premiums Attributed to Protected Cells Exhibit	1	EO	xxx	3/1	NAIC	
	24	Reinsurance Attestation Supplement	1	EO	xxx	3/1	Company	
	25	Reinsurance Summary Supplemental	1	EO	xxx	3/1	NAIC	
	26	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	
	27	Schedule SIS	1	N/A	N/A	3/1	NAIC	
	28	Statement of Actuarial Opinion	1	EO	xxx	3/1	Company	Y
	29	Supplement A to Schedule T	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	30	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	
	31	Trusted Surplus Statement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
		<b>III. ELECTRONIC FILING REQUIREMENTS</b>						
	50	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	51	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	52	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	53	Risk-Based Capital .PDF Filing	xxx	1	N/A	3/1	NAIC	
	54	Combined Annual Statement Electronic Filing	xxx	1	xxx	5/1	NAIC	
	55	Combined Annual Statement .PDF Filing	xxx	1	xxx	5/1	NAIC	
	56	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	57	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	58	Quarterly Statement Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	59	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	60	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		<b>IV. AUDITED FINANCIAL STATEMENTS</b>						
	71	Accountants Letter of Qualifications	1	EO	N/A	6/1	Company	X
	72	Audited Financial Statements	1	EO	xxx	6/1	Company	X
	73	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	X
	74	Independent CPA	1	N/A	N/A		Company	X
	75	Notification of Adverse Financial Condition	1	N/A	N/A		Company	X
	76	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	X
	77	Request for Exemption to File	1	N/A	N/A		Company	X
	78	Request to File Consolidated Audited Annual Statements	1	N/A	N/A		Company	X
		<b>V. STATE REQUIRED FILINGS</b>						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	P
	103	Copy of Annual Statement Montana State Page w/Tax Report	1	0	1	3/1	Company	
	104	Filings Checklist Page 1 (with Column 1 completed)	1	0	1	3/1	State	
	105	Genetics Program Charge Form (GP-09)	1	0	1	3/1	State	Q
	106	Holding Company Statement	1	0	0	4/30	State	
	107	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	R
	108	Montana Comprehensive Health Association (MCHA-09) Survey	1	0	1	3/1	State	S
	109	Montana Medical Malpractice Professional Liability Experience	1	0	1	3/1	State	T
	110	Montana Premium Tax Report & Remittance (SAI 28)	1	0	1	3/1	State	
	111	Quarterly Premium Tax Forms (SAI 23)	1	0	1	4/15, 6/15, 9/15, 12/15	State	U
	112	Report of Insured Montana Residents (RIMR-09)	1	0	1	3/1	State	V
	113	Small Employer Group Activity Report (SEHRP-09)	1	0	1	3/1	State	W
	114	State Filing Fees	1	0	1	3/1	State	
	115	Signed Jurat	0	xxx	1	3/1	NAIC	L

\*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing). \*\*If Form Source is NAIC, the form should be obtained from the appropriate vendor.

	<b>NOTES AND INSTRUCTIONS (A-N APPLY TO ALL FILINGS)</b>
A	<b>Required Filings Contact Person:</b> Montana Insurance Department, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at <a href="mailto:cdonovan@mt.gov">cdonovan@mt.gov</a> ; Michelle Scaccia at <a href="mailto:mscaccia@mt.gov">mscaccia@mt.gov</a> ; Tim Morris at <a href="mailto:tmorris@mt.gov">tmorris@mt.gov</a> ; Wayne Barker at <a href="mailto:wbarker@mt.gov">wbarker@mt.gov</a>
B	<b>Mailing Address:</b> Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	<b>Mailing Address for Filing Fees:</b> Mailing address is same as above. The fee of \$1,900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.
D	<b>Mailing Address for Premium Tax Payments:</b> Same as B.
E	<b>Delivery Instructions:</b> Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day. The premium tax return (SAI 28) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on yellow paper. If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. <b>DO NOT</b> combine amounts for groups of companies. Note that the tax return requires all companies remit a check for \$1,900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2009, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2010 quarterly premium tax prepayments. Montana Administrative Rules pertaining to tax payments: <u>6.6.2706 Adjustments</u> (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. <u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. <u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. <u>6.6.2708 Application of Refund</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.
F	<b>Late Filings:</b> The commissioner may impose a fine [Sections 33-2-701(6) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]
G	<b>Original Signatures:</b> Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	<b>Signature/Notarization/Certification:</b> Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	<b>Amended Filings:</b> See NAIC Annual Statement Instructions for guidance on amended filings.
J	<b>Exceptions from normal filings:</b> Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	<b>Bar Codes (State or NAIC):</b> Montana is not currently using Bar Codes.
L	<b>Signed Jurat:</b> Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refilled or amended, a newly completed Jurat page is required.
M	<b>NONE Filings:</b> See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	<b>Filings new, discontinued or modified materially since last year:</b> None of the filings have been discontinued since last year. New NAIC Supplement Filing: Bail Bond Supplement Line #12
O	<b>Certificate of Compliance:</b> Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
P	<b>Certificate of Deposit:</b> Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders, along with a detailed description, including CUSIP# (if available), par value, and/or amortized value and/or market value for each security listed based on the information maintained by insurer's state of domicile. Due March 1.

Q	<p><b>Genetics Program Charge Form (GP-09):</b></p> <p>Pursuant to Section 33-2-712 MCA, an insurer is required to pay a fee of \$1.00 to the Commissioner of Insurance per Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is enclosed in your packet if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. <b>REPORT IS DUE EVEN IF REPORTING ZERO.</b></p>
R	<p><b>Insurance Department Financial Examination Report:</b></p> <p>A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.</p>
S	<p><b>Montana Comprehensive Health Association (MCHA-09) Survey:</b></p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. <b>REPORT IS DUE EVEN IF REPORTING ZERO.</b></p>
T	<p><b>Montana Medical Malpractice Professional Liability Experience Report:</b></p> <p><b><u>2005 legislation requires this report from all Property/Casualty insurers writing medical malpractice professional liability insurance</u></b> in Montana [Section 33-23-310, MCA]. Due March 1.</p>
U	<p><b>Quarterly Premium Tax Forms and Instructions (SAI 23):</b></p> <p>Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2010 premium taxes on a quarterly basis on or before the 15<sup>th</sup> day of the following months: April, June, September, and December.</p> <p><b><u>6.6.2704 Methods of Calculation</u></b> (1) Every insurer shall pay its quarterly premium tax obligation as follows:  (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or  (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments.</p> <p><b><u>6.6.2707 Cessation of Business</u></b> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.</p> <p>Include with the 2010 quarterly premium tax remittances a completed voucher form SAI 23. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2010, <b><u>please return all four voucher forms marked "zero" with the April 15 filing.</u></b></p> <p>The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.</p>
V	<p><b>Report of Insured Montana Residents (RIMR-09):</b></p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. <b>REPORT IS DUE EVEN IF REPORTING ZERO.</b></p>
W	<p><b>Small Employer Group Activity Report (SEHRP-09):</b></p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. <b>REPORT IS DUE EVEN IF REPORTING ZERO.</b></p>
X	<p><b>Audited Financial Statements:</b></p> <p><b>FOREIGN INSURERS ONLY</b> – Please refrain from submitting the Audited Financial Statements to this office until further notice.</p>
Y	<p><b>Statement of Actuarial Opinion:</b></p> <p>Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.</p>

**General Instructions  
For Companies to Use Checklist**

**Please Note:** This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

**Electronic filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.**

**Column (1) (Checklist)**

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

**Column (2) (Line #)**

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

**Column (3) (Required Filings)**

Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Risk -Based Capital .PDF Filing*** is the .pdf file for risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions*.

The ***Supplemental .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Statement Electronic Filing*** includes the complete quarterly statement data.

The ***Quarterly Statement .PDF Filing*** is the .pdf file for quarterly statement data.

The ***Combined Annual Statement Electronic Filing*** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The ***Combined Annual Statement .PDF Filing*** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements.

**Column (4) (Number of Copies)**

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

**Column (5) (Due Date)**

Indicates the date on which the company must file the form.

**Column (6) (Form Source)**

This column contains one of three words: "NAIC," "State," or "Company." If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

**Column (7) (Applicable Notes)**

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.



MONTANA INSURANCE DEPARTMENT  
840 HELENA AVENUE  
HELENA, MONTANA 59601  
(406) 444-2040

**2009**  
**ANNUAL PREMIUM**  
**TAX STATEMENT**  
**FIRE COMPANIES**  
**CASUALTY COMPANIES**

<b>Insurer Name</b>				<b>NAIC Number</b>	
<b>Company Mailing Address</b>		<b>check if new</b> <input type="checkbox"/>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Tax Contact Mailing Address</b>		<b>check if new</b> <input type="checkbox"/>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>State of Domicile</b>		<b>Tax &amp; Fee Contact Person</b>		<b>Tax Contact Person Telephone Number</b>	
<b>Administrative Office Telephone and Fax Numbers</b>			<b>Toll Free Telephone Number for Policyholder Inquiries</b>		

**SCHEDULE A - PREMIUM TAX CALCULATION**

- |   |          |     |
|---|----------|-----|
| 1. Total Direct premium income (Ann. Stmt: P/C-pg 19, ln 35, col 1; Health-pg 29, ln 12 & 14, col 1; Title-pg 38, ln 27, col 3, 4, 5) | \$ _____ | [1] |
| 2. Finance and service charges (Ann. Stmt: P/C-page 19 footnote a)  | \$ _____ | [2] |
| 3. TOTAL PREMIUMS COLLECTED (add lines 1 and 2)   | \$ _____ | [3] |
| 4. Dividends refunded or credited to policyholders (Ann. Stmt.: P/C-page 19, line 35, column 3)                                       | \$ _____ | [4] |
| 5. Federal Exemptions - Medicare Title XVIII/Multi-Peril Crop   | \$ _____ | [5] |
| 6. NET PREMIUMS per 33-2-705(1), MCA (line 3 less line 4 and 5)   | \$ _____ | [6] |
| 7. PREMIUM TAX per 33-2-705(2), MCA (2.75% of line 6)   | \$ _____ | [7] |

**SCHEDULE B - FIRE INSURANCE PREMIUM TAX CALCULATION**

Taxes are due and payable on the fire portion of the net direct premiums on risks resident, situated or located in Montana. Dollar amount and percentages must be used so that the calculation can be traced to the annual statement. References to rating organizations are not acceptable. Amounts in column IV are to be derived by multiplying amounts in column II by percentages in column III.

	I	II	III	IV	
	LINE OF BUSINESS	ANNUAL STMT. PG. 19, COL. 1 DIRECT PREMIUM	% ALLOCATION OF FIRE RISK	DOLLAR AMOUNT OF FIRE PREMIUMS	
8.	Fire		100%		[8]
9.	Allied Lines				[9]
10.	Farmowners Multi Peril				[10]
11.	Homeowners Multi Peril				[11]
12.	Commercial Multi Peril				[12]
13.	Ocean Marine				[13]
14.	Inland Marine				[14]
15.	Other Private Passenger Auto Liability				[15]
16.	Other Commercial Auto Liability				[16]
17.	Private Passenger Auto Physical Damage				[17]
18.	Commercial Auto Physical Damage				[18]
19.	Aircraft				[19]
20.	Burglary & Theft				[20]
21.	Boiler & Machinery				[21]

- |     |   |          |      |
|-----|---|----------|------|
| 22. | Total Net Fire Premiums (add lines 8 thru 21, column IV)              | \$ _____ | [22] |
| 23. | Tax on Fire Insurance Premiums per 50-3-109(1), MCA (2.5% of line 22) | \$ _____ | [23] |

SCHEDULE C -- CALCULATION OF TOTAL TAXES AND FEES

24.	Premium Tax (from line 7)	\$ _____ [24]
25.	Retaliatory Amount per 33-2-709, MCA (from Schedule E, Line 3 or 4)	\$ _____ [25]
26.	TOTAL (Add lines 24 and 25)	\$ _____ [26]
27.	Montana premium tax quarterly pre-payments	\$ _____ [27]
28.	Overpayments of prior year premium taxes (as confirmed by credit letter)	\$ _____ [28]
29.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2004-2008, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	\$ _____ [29]
30.	100% of Assessments paid in 2009 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	\$ _____ [30]
31.	Empowerment Zone New Employees – tax credit (include copy of certification from Montana Department of Labor and Industry).	\$ _____ [31]
32.	Gross Deductions (add lines 29, 30 and 31)	\$ _____ [32]
33.	Allowable Deductions (enter the smaller of line 24 or line 32)	\$ _____ [33]
34.	Total payments and credits (add lines 27, 28 and 33)	\$ _____ [34]
35.	If line 26 is larger than line 34, DIFFERENCE is TAX DUE	\$ _____ [35]
36.	Fire Insurance Premium Tax (from Schedule B line 23)	\$ _____ [36]
37.	COMPANIES MUST REMIT \$1,900 IN PAYMENT OF ALL MONTANA FEES	\$ _____ \$1,900.00 [37]
38.	TOTAL REMITTANCE (add lines 35, 36 and 37)	\$ _____ [38]
39.	If line 34 is larger than line 26, DIFFERENCE is ANNUAL TAX OVERPAYMENT	\$ _____ [39]

**OVERPAYMENT must be carried forward and used to offset future periodic payments.**

The above statement, and attached Schedules D and E, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

- TAX RETURN CHECKLIST** Did You Remember to:
- 1. \_\_\_\_\_ Attach Annual Statement Montana State Page?
  - 2. \_\_\_\_\_ Include Total Remittance from line 38 (at least \$1,900)?
  - 3. \_\_\_\_\_ Attach documentation for tax credits on lines 29, 30 and 31?
  - 4. \_\_\_\_\_ Indicate your company's NAIC number on front of the tax form?
  - 5. \_\_\_\_\_ Attach explanations for any unusual or extraordinary items?
  - 6. \_\_\_\_\_ Fully complete Schedules D and E and attach them to this statement?

CO. NAME \_\_\_\_\_ NAIC # \_\_\_\_\_ STATE OF DOMICILE \_\_\_\_\_

**SCHEDULE D -- RETALIATORY SCHEDULE**

**ATTACHMENT TO 2009 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES  
STATE OF MONTANA**


	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 6)	_____	_____
2. Tax Rate	2.75% _____	_____
3. Premium Tax	_____	_____
4. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	\$1,900.00 _____	_____
5. Annual Statement Filing Fee	N/A	_____
6. Assessment for Insurance Department Operations	N/A	_____
7. Montana Fire Insurance Premium Tax (from Schedule B, Line 23)	_____	N/A
8. Fire Marshal Tax	N/A	_____
9. Other Fire Taxes (explain)_____	N/A	_____
10. Other (explain)_____	N/A	_____
11. Other (explain)_____	N/A	_____
12. Total Montana Taxes & Fees (add lines 3 thru 7, col. A)	_____	XXXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (add 3 thru 6, and 8 thru 11, col. B)	XXXXXXXXXXXX	_____

**SCHEDULE E -- CALCULATION OF RETALIATORY TAX**

**ATTACHMENT TO 2009 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES  
STATE OF MONTANA**


1. Enter Amount from Schedule D, Line 13, Col. B \_\_\_\_\_
2. Enter Amount from Schedule D, Line 12, Col. A \_\_\_\_\_
3. If Schedule E, Line 1 is larger than Schedule E, Line 2 enter difference on this line and transfer this amount to Schedule C, Line 25 \_\_\_\_\_
4. If Schedule E, Line 2 is larger than Schedule E, Line 1, enter \$0 on this line and transfer \$0 to Schedule C, Line 25 \_\_\_\_\_

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

 <p><b>MONTANA INSURANCE DEPARTMENT</b>  <b>840 HELENA AVENUE</b>  <b>HELENA, MONTANA 59601</b>  <b>(406) 444-2040</b></p>		<p><b>PREMIUM TAX REFUND REQUEST FORM</b></p> <p style="text-align: right;">6.6.2708, ARM</p>	
Insurer Name			NAIC Number
Mailing Address	City	State	Zip Code
State of Domicile	Contact Person and Telephone Number		FEIN Number
<b>Reason for decrease in estimated premium tax liability for 2010.</b>		<b>Method of calculation for refund.</b> Calculation subject to audit by Department  A. 2009 Overpayment \$ _____  2010 Pre-payment Requirement:  B. 100% of 2009 Tax \$ _____ or C. 90% of 2010 Tax * \$ _____  1. 2009 Overpayment \$ _____ (A from above)  2. Prepayment required \$ _____ (B or C from above)  3. Amount of Refund \$ _____ (1 minus 2)  * Please explain in left hand column.	
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
<p>Subscribed and sworn to before me this _____ day of _____, 20 ____.</p> <p style="text-align: right;">_____(Notary Public)</p> <p>Residing at _____</p> <p>My commission expires _____</p>			



**6.6.2707 Cessation of Business** (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

		<b>MONTANA INSURANCE DEPARTMENT</b> <b>840 HELENA AVENUE</b> <b>HELENA, MONTANA 59601</b> <b>(406) 444-2040</b>		<b>CESSATION OF BUSINESS NOTIFICATION FORM</b>  6.6.2707, ARM	
Insurer Name				NAIC Number	
Mailing Address		City		State	Zip Code
State of Domicile	Contact Person and Telephone Number			FEIN #	
Explanation of adjustment to quarterly tax pre-payment.					
Title of Officer			Name of Officer (Type or Print)		
Date			Signature of Officer		
Subscribed and sworn to before me this _____ day of _____, 20__.					
_____ (Notary Public) Residing at _____ My commission expires _____					



**Montana Insurance Department**  
**840 Helena Avenue**  
**Helena, MT 59601**  
**(406) 444-2040**

## MONTANA MEDICAL MALPRACTICE PROFESSIONAL LIABILITY EXPERIENCE REPORT

**Pursuant to 33-23-310, MCA**

Supplement to 2009 Annual Statement for \_\_\_\_\_ (Company) \_\_\_\_\_ (NAIC#)

**To be filed March 1 (Surplus Lines - April 1).**

[illegible]



State of Montana

**PROPERTY AND CASUALTY INSURERS  
QUARTERLY PREMIUM TAX PAYMENT  
DUE DATE: APRIL 15, 2010**

Insurer Name: \_\_\_\_\_

NAIC # \_\_\_\_\_ Check Number: \_\_\_\_\_

**QUARTERLY TAX PAYMENT CALCULATION**

1. '09 premium tax liability (#7 from tax return)  
or 90% of anticipated 2010 tax \$ \_\_\_\_\_
2. Less allowable deductions (*See instructions on back*) \$ \_\_\_\_\_
3. Total 2010 quarterly pre-payment (*line #1 - #2*) \$ \_\_\_\_\_
4. Enter 25% of the amount on line #3 \$ \_\_\_\_\_
5. Amount of 2009 overpayment applied to this  
payment (*see line #39 of the tax return*) \$( \_\_\_\_\_ )
6. **QUARTERLY AMOUNT REMITTED (#4 - #5)** \$ \_\_\_\_\_  
(*Instructions on back*)

Mail payment to: Montana Ins Dept - 840 Helena Ave - Helena MT 59601

SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS  
QUARTERLY PREMIUM TAX PAYMENT  
DUE DATE: SEPTEMBER 15, 2010**

Insurer Name: \_\_\_\_\_

NAIC # \_\_\_\_\_ Check Number: \_\_\_\_\_

**QUARTERLY TAX PAYMENT CALCULATION**

1. '09 premium tax liability (#7 from tax return)  
or 90% of anticipated 2010 tax \$ \_\_\_\_\_
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SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS  
QUARTERLY PREMIUM TAX PAYMENT  
DUE DATE: JUNE 15, 2010**

Insurer Name: \_\_\_\_\_

NAIC # \_\_\_\_\_ Check Number: \_\_\_\_\_

**QUARTERLY TAX PAYMENT CALCULATION**

1. '09 premium tax liability (#7 from tax return)  
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SAI-23 (11/09)



State of Montana

**PROPERTY AND CASUALTY INSURERS  
QUARTERLY PREMIUM TAX PAYMENT  
DUE DATE: DECEMBER 15, 2010**

Insurer Name: \_\_\_\_\_

NAIC # \_\_\_\_\_ Check Number: \_\_\_\_\_

**QUARTERLY TAX PAYMENT CALCULATION**

1. '09 premium tax liability (#7 from tax return)  
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SAI-23 (11/09)

**QUARTERLY TAX PAYMENT INSTRUCTIONS**

**Line #2 Instructions**

The quarterly amounts should be reduced by subtracting the following **allowable deductions**:

- A. Anticipated 2010 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2005-2009): \$ \_\_\_\_\_
- B. Montana Comprehensive Health Association assessments: \$ \_\_\_\_\_  
(excluding HIPAA Plan Liability assessments)
- Total allowable deductions to transfer to line #2 (on front):** \$ \_\_\_\_\_

**Other Instructions**

**Please do not** combine amounts for affiliated companies on a single check.

**If the amount on line #3 is zero or a negative amount:** Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2010.

If insurer deems the total 2010 quarterly pre-payment requirement on line #3 to be a minimal amount (less than \$100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2010.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2010 anticipated premium tax.

**If you have any questions, please contact our office at (406) 444-2040.**

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